

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039883
5825 STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED NOV 7 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	JACKSON	a. STATE	MISSOURI
b. CITY (If outside corporate limits, give TOWNSHIP only)	KANSAS CITY	b. COUNTY	JACKSON
Length of stay in 1b	10 YEARS	c. CITY OR TOWN	KANSAS CITY
c. FULL NAME OF (If NOT in hospital, give location)	BAPTIST MEMORIAL HOSP.	d. STREET ADDRESS	9200 WORNALL RD.
Inside Limits	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
ESTHER		ELLIOTT		OCTOBER	27	1963	

5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
FEMALE	WHITE		7-4-1906	57 YEARS	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
CLERK	AAA CLUB OF MO.	HOLDEN, MO.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
WILLIAM W. HOWARD	EMMA BEARD	FLOYD F. (DECEASED)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.		FLOYD A. ELLIOTT 9200 WORNALL RD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		31 Hours
IMMEDIATE CAUSE (a)	MASSIVE HEMORRHAGE INTO PONS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	HYPERTENSIVE CARDIOVASCULAR DISEASE	unknown
DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY	Hour	Month, Day, Year
	a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from	25 October 63	to	27 October 63	and last saw her alive on	26 October 1963.
Death occurred at	12:25 (10:27-63) A	m	on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE	22b. ADDRESS	22c. DATE SIGNED
Raymond F. Stone, M.D.	7949 State Line, K.C. Mo.	10-28-63.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
BURIAL	10-29-1963	LEES SUMMIT CEMETERY	LEES SUMMIT,	MISSOURI

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
MUEHLEBACH	6800 TROOST	10-28-63	Beaie Smith

(Licensed Embelmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Raymond F. Stone, M.D.

DATE AMENDED

VS 300
Rev. 4/59

1
2 3938
3
4 1
5 2
6
7 0
8 1
9 4/4/3x
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11
12 50-0
13

Walter J. Stelmach
7951 State Line
HI-4-7367
after 11:00 PM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert J. Landes

Licensed Embalmer No.

5103

P. O. Address

H.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.